ACCESS

Newsletter of the Nebraska Office of Rural Health, Nebraska Department of Health & Human Services, Division of Public Health *and the* Nebraska Rural Health Association for all rural health stakeholders

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contents

Finding help with HIT adoption

by David Howe

Healthcare reform and health information technology have met, producing a "starburst" of grant programs, incentives and disincentives, deadlines, new organizations, new alliances, and new policies and procedures.

What are rural healthcare providers to do?

Neal Neuberger, Executive Director of the Institute of e-Health Policy and President of Health Tech Strategies, LLC, at McLean, Va., offered some views on that at the September Nebraska Rural Health Conference in Kearney.

Many rural providers face challenges, such as not having information technology (IT) support, let alone an IT department, and lacking strength-in-numbers buying power for purchases such as HIT services.

A staff of just 30-plus people has been putting into action the American Recovery and Reinvestment Act's HIT provisions, according to Neuberger. But, he added, the Federal Government is "starting to pay more attention" to actions under those provisions, which include:

- Office of National Coordinator required to assess use of HIT in reducing disparities as part of its duties.
- Required studies on impact of HIT on communities with health disparities and uninsured, underinsured, and medically underserved communities.
- Secretary of HHS report on matters related to aging services technology assistance.
- Grant funding to be consistent with Health and Human Services policies on inclusion of women and minorities research.
- HIT research Centers to prioritize assistance to non-profits, CAHs, rural, small practices and organizations that serve unserved and underserved communities.

Up to $50 billion of the $787 billion in the American Recovery and Reinvestment Act (ARRA), is for "Cyber Ready" HIT efforts, according to Neuberger. That includes infrastructure, public-private partnerships, and support for broader healthcare reforms relating to access, efficiency, and quality.

Of course, that includes incentives to providers for adoption of electronic medical records (EMRs) in stages over the next several years through the Centers for Medicare and Medicaid.

Among the many HIT efforts funded under ARRA are grants to establish Regional Health Information Technology Extension Centers that rural providers can go to for technical assistance, guidance, and information on electronic health records best practices.

(Wide River Technology Extension Center is the regional technology extension center in Nebraska, which can be found online at www.widerivertec.org. It's one of about 60 such centers across the nation.)

Neuberger had a long list of government organizations through which HIT grant and

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assistance programs are available. They include ONCHIT, the Social Security Administration, Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), National Telecommunications and Information Administration (NIST), Rural Utilities Services (RUS), Employment and Training Administration (ETA), National Institute of Standards and Technology (NIST) and the Veterans Health Administration.

At the same time, there are a number of state initiatives and private sector organizations that have roles in adoption of HIT, Neuberger said. The latter include such organizations as the American Telemedicine Association, Health Information and Management Systems Society, eHealth Initiative, the American Medical Informatics Association, and the American Health Information Management Association.

Neuberger listed other HIT efforts, including creation of a national HIT Research Center to Coordinate Regional Extension Centers. It's referred to as the "mother of all centers" and is the hub into which the aforementioned Regional Health Information Technology Extension Centers are connected. Neuberger also mentioned HRSA's efforts with $500 million in ARRA workforce funding, some of which is to be used for HIT workforce training.

In Q & A following his Kearney presentation, Neuberger was asked how to track down grants and other sources of assistance that rural providers can call upon for HIT implementation. He advised beginning by working through state associations, one example for Nebraska providers being the Nebraska Hospital Association.

It may be necessary to form a "grant cooperative," through which rural providers can search for and apply for grants to assist them in adopting HIT, interjected Denny Berens of the Nebraska Office of Rural Health in the Nebraska Department of Health and Human Resources.

Neuberger said there is currently a need for as many as 200,000 HIT workers in the U.S. Technology companies such as Intel are beginning to recognize the future of HIT, he said, noting that 25,000 to 30,000 attended a recent HIT trade show in the U.S. ☐

Health information in rural communities: Creighton study examines health information from a rural resident perspective

By Dr. Sue Crawford, Project Director

Researchers at the Creighton University Center for Health Services Research and Patient Safety (CHRP) are currently engaged in a multi-year study to understand health information from a rural consumer perspective. The study pays particular attention to the community infrastructures that enable consumers to improve their access and use of health information. Community infrastructures are interpreted very broadly to include resources such as community newspapers, gathering places where residents share information, connections between health systems and community partners, partnerships between health care providers and community entities such as schools, churches and other organizations, as well as resources that allow residents to access information from outside the local community such as internet or telehealth resources. The study also asks patients and health care providers to identify health information challenges that limit the effectiveness of health information to make a real difference in the lives of residents or potentially threaten patient safety to identify

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vulnerabilities in community infrastructures.

The current study builds on an earlier pilot study supported by the Office of Rural Health. That study included interviews with a few community leaders, health care providers, and residents from two rural communities as well as a follow up survey of a random sample of rural residents from several rural counties in Nebraska. The results from that pilot study revealed the wide variety of places and people to which residents turn for health information as well as the range of community resources that provide health information to consumers. The pilot study also illustrated the challenge patients have in managing their personal health information. Common responses to questions about how they manage their personal health information often included responses such as "not very well," and "I just keep it in my head."

A grant from the Agency for Health Care Research and Quality (AHRQ) within the federal Department of Health and Human Services has allowed CHRP to expand this earlier research. The funds come from a larger grant that supports the development of patient safety research at CHRP. The CHRP research team for this study includes experts from pharmacy, occupational therapy, physical therapy, emergency medical services, sociology, political science, and health administration. This summer and fall faculty and student researchers have been in two Nebraska communities talking with more residents, health care professionals, and community educators. Plans are underway to include a panhandle community in the study as well. The intensive look at three specific rural communities will provide a rich picture of consumers' perspectives of their access to health information in their communities as well as health care professionals' view of how they fit into the picture. The grant also provides funds for a follow up survey of rural residents across Nebraska. That survey will provide evidence of how experiences of residents in the three target communities compare to those of other rural communities and an opportunity to learn more about how rural residents access, manage, and use health information.

If you have questions about the study or suggestions to offer, please contact our project coordinator, Kelly McColley-Anderson (402)-280-3426. This project is supported by grant number R24HS018625 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality; Principal Investigator: Kimberly Galt, Pharm.D.,Ph.D.; IRB # 09-15470. □

Why study this?

Improving patient safety, reducing costs, improving quality, improving communication between patients and multiple health care providers, and empowering patients to take more responsibility for their health care all require good health information management and communication. Opportunities to improve health by strengthening health information in rural areas go far beyond electronic record implementation alone. Improving patient-centered care and patient safety requires attention to the various ways in which patients and health care providers in our rural communities share, access and manage information to take care of themselves and make good use of health care professionals in their communities. However, little is known about how residents actually tackle these information tasks in their communities. Knowing more about what works and what does not work will inform the development of effective health information strategies that fit rural consumer needs.

The Nebraska Rural Response Hotline

Marilyn P. Mecham, Executive
Interchurch Ministries of Nebraska

"To get help for a young child as to what to do or what to do next was so helpful. Now we are on the right track. COMHT made counseling possible for my children. What a relief! ***Thank you so much."***

This is one of many comments received by the Nebraska Rural Response Hotline staff from parents whose children received counseling through the Counseling Outreach Mental Health Therapy Program. As the numbers of calls to the Hotline continue to increase (3,219 calls from January through August 2010), so does the number of calls seeking mental health support for rural children. During the first eight months of this year, 1,613 counseling vouchers were used by callers to the Hotline; 387 of those vouchers were for children under 18. Another 176 vouchers served young people ages 18 to 24.

Counselors report that issues included bullying, adjusting to new situations -- including blended families -- depression, and abuse. If there is any good news in the increase in the numbers of vouchers used, it is that parents are seeing, and often personally experiencing, the benefit of mental health counseling and are seeking help for their children at an earlier age. Although we have a long way to go, some of the stigma is being lifted.

The Hotline was used again in the spring and summer of 2010 for disaster response throughout Nebraska. Floods and hail devastated many counties, destroying acres of crops and killing livestock. Based on past experience, the number of calls to the Hotlin in October and November, March and April will peak as farm families cope with the impact of lost crops. Financial assistance for those affected by the floods is available through the Hotline, thanks to the support of Nebraska churches.

Due to the intensity of the calls to the Hotline and with the support of a SAMHSA grant, greater emphasis is being put on suicide prevention. Trainings and resources are shared in communities throughout Nebraska.

The Rural Response Hotline has expanded its outreach to military personnel returning to rural Nebraska. Danielle Sodergren is the suicide prevention and military outreach coordinator for Interchurch Ministries of Nebraska. Danielle coordinates outreach efforts with the National Guard, the Veteran's Administration, Family Readiness Groups, and national and local veterans' organizations. Veterans used 43 vouchers between January and August. Because of the number of military personnel deployed the past 12 months, we anticipate a greater demand for the Hotline services as these men and women return to the rural areas in 2011. Information about the Hotline is shared with the soldiers and their families at deployment and welcome home events.

A farmer recently said, "This Hotline is a great program for Nebraska! The farmers of this state are dedicated and hard working people."

To find out more about the Nebraska Rural Response Hotline and all the services the staff provides Nebraska's dedicated and hard working people, call (800) 464-0256.☐

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If you have any questions, please e-mail Ann.Larimer@nebraska.gov.

Advice to rural providers under health reform: take the lead

By David Howe

Healthcare reform is here to stay.

Chances of the Patient Protection and Affordable Care Act being repealed entirely are "close to zero," noted Dr. Keith Mueller in his hour-long presentation to the Nebraska Rural Health Association Conference in Kearney in September.

Rural healthcare needs to embrace the opportunities the Act offers, Mueller told the conference. It's a matter of choosing leading over following. By leading, rural healthcare providers can "make changes happen in a favorable way," said Mueller, who now heads the Department of Health Management and Policy in the College of Public Health at Iowa University.

The former director of the Nebraska Rural Health Research Center at UNMC laid out several ways rural healthcare can lead the way for favorable changes under healthcare reform. The changes must:

- Be systemic.
- Be created locally, "perhaps with ideas from national policy."
- Be facilitated through regional collaboration. That can include integrated systems of seamless care.
- Be supported by national policy and resources.

At least 33 million of the uninsured targeted by healthcare reform must be enrolled to make assumptions such as improved access under healthcare reform work. That still leaves another 20 million that need to be found and enrolled through Medicaid or insurance, he added.

Rural healthcare providers need to think in terms of a new framework, Mueller continued. That includes e-health and optimal use of all persons in the workforce, which may involve new categories of workforce and making the most of technology such as 24/7 pharmacy order review and consultations through health information technology.

Mueller underscored the importance of concentrating on making services available locally, including such services as E-ICU®, mental/behavioral health, and dermatology. That helps make it possible for people to remain in the local community for their care, making primary care in rural communities more appealing, he said.

Optimal use of healthcare professionals through such approaches as a patient-centered medical home model and non-physician primary care providers were other suggestions.

Integrating public health thinking and planning with the patient-centered medical home model was yet another suggestion.

An important aspect of healthcare reform is bending down the cost curve through expanded coverage. That might be seen as "good news, bad news, good news," Mueller noted. Coverage of the heretofore uninsured will lead to more appropriate care (good news). But that added care means more cost in the short term (bad news). But, as the benefits of appropriate care reduce health care needs long-term, the cost curve begins to bend down (good news).

Slowing or reversing unsustainable trends will lead to more access to healthcare services, Mueller said.

Payment for health services will be value-based. "It's here to stay," Mueller said. "Everyone will be paid on some kind of value-based scale." How a value-based system proceeds will involve changes in the system, Mueller noted. Some of those changes that he foresees:

- Factors that drive adoption of integrated systems of care, including quality measures applied to patient transfers.
- More emphasis on care in the home, using electronic health information systems, remote monitoring, and mobile diagnostic technology.
- Community health teams with patient-centered medical homes.
- Regionalized systems for emergency care.

Mueller said the Secretary of Health and Human Services "is given a lot of authority" in developing system changes. The Secretary is to develop a national strategy by January 1 to

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improve the delivery of healthcare services, patient health outcomes and population health. The Secretary is also to develop "quality measures assessing health outcomes and functional status, management and coordination across episodes and care transition," as well assessing experience, quality, and use of information provided to and used by patients.

Much of the emphasis in healthcare reform is on prevention. Title IV, subtitle A of the Act includes a new National Prevention, Health Promotion and Public Health Council that will address ways to think about health and wellness, according to Mueller. Secretaries of major federal agencies such as the Departments of Agriculture, Commerce, Energy, and Transportation, will serve on the Council.

The Council will be advised by an Advisory Group on Prevention, Health Promotion, and Integrative Public Health, according to Mueller. Various categories of people will comprise the advisory group, he said. Funding for these groups will come from a new Prevention and Public Health Fund, he said.

Also under that subtitle, the Centers for Disease Control and Prevention is to convene an independent Community Preventive Services Taskforce.

Activities under Subtitle A, according to Mueller, include:

- Planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span.
- Establishing and implementing a national science based media campaign on health promotion and disease prevention.

Other parts of Title IV, according to Mueller, include a focus on preventive medicine measures. Among them are:

- School-based health centers.
- Medicare coverage of personalized prevention plan services.
- CDC grants for implementation , evaluation and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming.
- Grants to provide public health community interventions, screenings, and clinical referrals for persons between ages 55 and 64.

"Change is coming--and with a sense of urgency," Mueller said, adding that the change "could be very helpful to rural healthcare delivery if shaped locally and regionally." ☐

Dental grants to serve rural Nebraska

The UNMC College of Dentistry received a $1.2 M HRSA grant for the COD pediatric dental residency program. The grant will allow the pediatric dental residents to increase the number of rural health rotations they conduct, train physicians about infant oral health, and will demonstrate the use of tele-dentistry services in rural physician's offices. The purpose of the project is to provide pediatric dental expertise throughout the region and increase access to care for under-served populations.

The College of Dentistry also received a $2.3 M HRSA grant to expand its Service-Learning (SL) program to include Critical Access Hospitals (CAH's), implementing a new Inter-Professional Education (IPE) programs, and further develop the tele-dentistry network. The purpose of the project is to provide oral health services and expertise to rural and underserved populations as well as develop an inter-professional healthcare work force to serve the oral health needs of the region.

For more information, please contact David G Brown at dgbrown@unmc.edu, or Kimberly K McFarland at kmcfarland@unmc.edu. ☐

Rural dental service grant to Nebraska HHS

The oral health specialists who serve Nebraskans are as unevenly distributed across the state as is the general population. But new funding has become available to address that problem.

Nebraska's Office of Oral Health and Dentistry (OOHD) recently received funding to increase access to oral health services thanks to Health Resources and Services Administration. Up to 10 contracts with award amounts reaching $15,000 to $20,000 will be available to Federally Qualified Health Centers and (under LB 692) Nebraska Public Health Departments, those acting in accordance with the settlement funding provided in that legislative bill.

The Nebraska Dental Workforce Committee reports that Nebraska's two most populous counties (Douglas and Lancaster, which contain Omaha and Lincoln) account for 44 percent of the state's population and 56 percent of the dental workforce. Fifty-three of Nebraska's 93 counties have been designated as dental health professional shortage areas.

As of April 2008, 20 counties were reported to have no dentist, and an additional 32 counties had only one or two dentists.

The ratio of population-to-dentist was estimated as 1,787 to one for all of Nebraska. The contrast between urban and rural areas of the state is striking. In urban areas the population-to-dentist ratio is 1,517 to one, while the ratio in the remaining 90 rural counties is 9,960 to one.

The uneven distribution of dentists is complicated by the fact that many of them are presently nearing retirement age. A 2007 projection by the University of Nebraska Medical Center Health Professions Tracking Center revealed that 24 percent of Nebraska's dentists planned to retire by 2017.

The OOHD invites qualified agencies throughout the state to apply for our funding. Contractors will choose to work with WIC, Head Start/Early Head Start, childcare centers, or preschool settings to provide needed education, fluoride varnish applications, and dental supplies.

The target populations for these projects are low-income and minority children up to 8 years of age; children with special health care needs; children with limited access to oral health care; and those not being reached by existing preventive oral health programs.

Applications will be available mid October and will be due late November 2010.

For more information, contact:

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MARK YOUR CALENDARS

Nebraska Rural Health Advisory Commission Meeting
November 12, 2010 - 1:30 p.m. - Lincoln, NE

NRHA Rural Multiracial and Multicultural Health Conference
Dec. 1 - 3, 2010 - Tucson, AZ

NRHA Rural Health Policy Institute
January 24-26, 2011 - Washington, DC

NRHA Rural Medical Educators Conference
May 3, 2011 - Austin, TX

Annual NRHA Conference
May 3-6, 2011 - Austin, TX

2011 Annual Nebraska Rural Health Conference
September 15-16, 2011 - Kearney, NE - Holiday Inn
www.RuralHealthWeb.org

Education is key to hospice growth

By Tracy Rathe
Nebraska Hospice and Palliative Care Association

Autumn is a time when families come together, returning to places and people that provide them comfort. There really is "no place like home." In fact, the 2007 Nebraska End-of-Life Survey revealed that 92 percent of Nebraskans would like to stay in their homes, surrounded by family and loved ones, if they were facing a life-limiting illness. Hospice makes this happen.

It is the goal of the Nebraska Hospice and Palliative Care Association to see that more Nebraskans benefit from the services of local hospice providers each year, no matter where they live at the end of life. Hospice teams of physicians, nurses, social workers, chaplains, aides, therapists, and volunteers worked to meet the medical, emotional, psychological, spiritual, and bereavement needs of approximately 43 percent (6,600) of dying Nebraskans and their families last year.

The greatest challenge faced in the Association's mission to increase hospice usage is the lack of understanding among Nebraskans that hospice can support them and their loved ones; hospice is a benefit of Medicare, Medicaid, the VA, and some private insurance plans if given a terminal prognosis; and they have the right to bring up the hospice option to their physicians. This education hurdle extends across both rural and urban settings.

Challenges deepen in rural Nebraska. With hospice providers located farther between one another, a rural hospice's service area can be as much as 100 miles as it works to reach dying Nebraskans. Federal regulatory and reimbursement scrutiny aims to ensure accountability, but it also creates financial challenges for hospices that are already stretched by increased fuel costs and staff travel time. Even with lessening resources, hospices continue to serve those at the end of life with their unique type of care.

Nebraska has 41 State-licensed hospices, with an additional 13 satellite locations. Find a hospice in provider in your area at nehospice.org or call (402)477-0204. ☐

Veterans hotline and online chat

With Help Comes Hope

Are you in crisis? Please call 1-800-273-TALK
Are you feeling desperate, alone or hopeless? Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to the nearest crisis center to you.

- Call for yourself or someone you care about
- Free and confidential
- A network of more than 140 crisis centers nationwide
- Available 24/7

Suicide prevention resources:

Nebraska State Suicide Prevention Coalition: www.suicideprevention.nebraska.edu

Nebraska Rural Response Hotline: (800) 464-0258.

Life Course Health

How do we encouraging young women and men to pursue healthier choices? The statistics are startling: nearly 10 percent of babies in Nebraska are born preterm (2007), and one out of 14 newborns is considered low birth weight (2008). Over the past 12 years, the number of babies with low birth weight in the state rose 12 percent, and preterm infants increased 25 percent.

Nebraska was one of 13 states to receive a federal grant to improve birth outcomes.

To understand the health concerns of young adults today, the Nebraska Department of Health and Human Services (NDHHS) talked with young women ages 16 to 25 across the state. Most of the women generally knew what they should do to be healthy, but admitted they often do not make appropriate choices. Many did not consider good health an issue that concerned them right now, believing they can change behaviors when they are older or have more time. Several other reasons cited included stress, time demands, money, friends and other relationships, and lack of self-esteem or goals for their future.

Research findings led to the launch of TUNE. "Live your life like it's your favorite song," is the theme of TUNE, a new initiative encouraging young adults in Nebraska to make positive healthy choices and take control of their lives, recently launched by the Nebraska Department of Health and Human Services (NDHHS).

TUNE recognizes the important role that music plays in the lives of young adults, and uses eight original songs written by local and regional artists. Tune uses music as a new way to connect with young people and provide the inspiration and information they need to live full, healthy lives. Tunemylife.org is a new website offering interactive elements including TUNE music, downloadable songs, artist interviews, health information that ties into song messages and links to additional health and wellness resources.

It is also important to encourage young people to make positive choices earlier in their lives. Based upon science and emerging practice, the Life Course Health model is a way to understand how physical health, emotional health, relationships, stress, education, and goal setting all play an important role in current and future health and success in all aspects of life.

Life Course Health focuses on 10 recommendations from the Centers for Disease Control and Prevention (CDC) for improvement of preconception health and health care nationwide. Life Course Health emphasizes that health is a resource for life, and identifies four ways that young adults can take responsibility for their health choices:

- Create a Life Course Health Plan
- Become health literate.
- Manage their health.
- Communicate with their doctors or other health care providers through regular conversations about health issues and concerns.

New Life Course Health tools were developed to help you integrate health and wellness topics into your daily interactions with patients. As a health care professional, you play a unique role in the lives of young adults. Young adults respect the opinions of their health care providers and view the information that they receive from you as valuable. As you work with youth, we hope these new resources, particularly the Life Course Health Plan, can be incorporated in your health setting. It is important to reach young adults prior to getting pregnant. The earlier we get these messages out to young adults, the more healthy outcomes they will have in the future.

Health care professionals are encouraged to go to http://www.dhhs.ne.gov/tune, to download the Life Course Health Plan and review the library of Life Course Health resources. All of these tools are available at no cost. ☐

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If you have any questions, please e-mail Ann.Larimer@nebraska.gov.

Panhandle Dental Day

By David Brown

Panhandle Dental Day has become an annual tradition for the University of Nebraska Medical Center College of Dentistry (COD) in early June. The UNMC College of Dentistry works closely with the Panhandle District Health Department and dental professionals from across the state to arrange the trip, identify and select the patients, arrange housing and organize meals and special activities.

The inaugural Dental Day was held at the College of Dentistry in 1991 and is held twice a year. In 2004, Dr. Donald Taylor of Alliance asked if the college could hold Dental Day in the Panhandle. After considerable planning, the college began holding a Dental Day in the Panhandle starting in June 2005 and has continued each June since then. The first two Panhandle Dental Days were held in a school gymnasium in Alliance; however, recognition of need and requests from other localities around the Panhandle caused the planners to extend the Dental Day sites to various locations in the Panhandle. In one year, Dental Day was held in as many as six separate locations; however, this proved to spread the resources too thin and we have gone back to four locations, Sidney, Alliance, Chadron and Gordon.

In Sidney we collaborate with two dental offices; in Alliance with one office and Box Butte General Hospital; in Chadron with the satellite clinic of Community Action Partnerships of Western Nebraska and in Gordon with Gordon Memorial Hospital.

Dental Day planning starts soon after Christmas. The Panhandle District Health Department, under the direction of Kim Engel, works closely with school nurses and other health professionals who act as local program coordinators to identify children who could benefit from the Dental Day experience. The program is intended for children who have major oral health needs and have little or no access to care, for whatever reason. Most of the children are from low income families. Some children have Kids Connection (Medicaid) but many are uninsured and even children with Medicaid have difficulty finding a dentist who will accept them as a patient. After the children are identified, the local coordinators obtain the required parental consent and arrangements are made to have the children screened. This screening involves an examination, X-rays and a preliminary diagnosis and treatment plan. This is done early so that the activities during Dental Day can focus on providing care rather than screening patients. If a preliminary screening cannot be done, the children are appointed and the screening is done on-site at Dental Day. The screenings are done by local dentists, almost all of whom are COD graduates and who perform the screenings at no charge as an in-kind contribution to the program.

While all this is being done, Dr. Stan Harn and others at the college are busy recruiting students, staff and faculty and organizing them according to site, arranging housing, out of the ordinary travel plans and a myriad of other details.

In Sidney, Alliance and Chadron, the program utilizes existing dental offices, so only dental hand instruments and supplies need to be organized and transported from Lincoln. However, in Gordon, the program is set up in the emergency room areas of the hospital so the college needs to transport not only all of the dental hand instruments and supplies but also portable dental chairs, delivery units, operator chairs and compressors for the air and water syringes. This past June, we set up 15 dental operatories inside the hospital. This requires a truck and small trailer and additional collaboration from the Mission of Mercy to make the equipment available. Dr. Jim Jenkins is primarily responsible for this phase of the program.

One other major positive part of the program is that Box Butte General Hospital (Dan Griess, director) volunteers its facility and some of its staff to do operating room (OR) cases. We see about six to eight OR cases in the hospital. These OR opportunities are reserved for patients who have such extensive oral health problems or are very young or have behavioral issues that prevent them from being seen in a traditional dental

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office setting. Volunteer dental professionals from Omaha and North Platte and pediatric dental residents from Omaha staff the OR.

Finally the day comes for Panhandle Dental Day. On Thursday all the volunteers and many tubs of supplies and instruments are loaded onto a big highway bus and we drive to the Panhandle. The bus discharges people along the way; first Sidney, then Alliance and Chadron and finally Gordon. It is about a nine hour bus ride so people are already tired before they get there. Early the next morning, everyone gets a motel continental breakfast and hustles off to their assigned site to deliver dentistry for the whole day.

The story repeats itself Friday night and Saturday morning. We plan to see one patient about every hour for either restorative or dental hygiene. Some patients have both restorative and hygiene, and some patients have extensive work to be done and may be seen both morning and afternoon on Friday as well as Saturday morning. We work until noon Saturday, then, reverse the process on the bus, arriving back in Lincoln about 10:00 p.m.

The experiences for all of the volunteers are wonderful. Students appreciate the opportunity to work on patients that they often do not get to see at the college. Also they get to work with faculty on a collegial basis in a neutral location with everyone working toward the same goals of providing as much quality dental care to as many patients as possible. There are many stories of frightened children who leave smiling, grateful patents who bring their children back year after year because they have no other access to care and just the great camaraderie developed between and among students, staff and faculty. It is estimated that about 80% of the children seen in Gordon are annual visitors to Dental Day. The College with its portable equipment and volunteer services has become their dental home.

Funding for the Dental Day program comes from several sources. The primary funding comes from the Panhandle District Health Department, Ameritas Life Insurance Corporation, and the Sowers Club. There are a variety of other donations of money, food and services for the volunteers. Students, staff and faculty lend their time and expertise so that this year we were able to see 225 patients throughout the Panhandle and deliver about $120,000 in dental services at private practice rates. ☐

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importance of relationship building.

I also believe that rural communities are one of the “shelterbelts” in our society. They are the places where we find a degree of creativity, accountability, fertile minds/activities, and an interesting diversity that has come together to exist in the same place. All that is essential if the community is to survive.

Rural areas are where I find peace and strong relationships. Rural communities understand sustainability, and they understand connectedness. They also work hard at preserving accountability. Why? Because they have to in order to be sustained.

Please think about what these ideas and values bring to the table now as we discuss health and health care, workforce recruitment and retention. Rural values and connectedness are an asset as we work on these health and health care issues in our society. Rural communities are looking for the flexibility to deploy their models and other best practice models to care for their citizens and community. Rural matters are many and diverse.

Rural should matter to us as we see the value of smallness, uniqueness and one-of-a-kind creations. Think of the 78 million baby boomers as they near retirement. Could rural matter to many of them as they consider moving upon retirement?

Tie those thoughts to the idea that the community matters. I believe that our state and nation are beginning to reevaluate the role of the communities that we live in and the impact our economic and industrial models and demographics are having on these places we call home. I think we need to collectively work on the “matters” of rural and community if we are to sustain the values and resources that we hold dear.

Why? Because community matters. ☐

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ACCESSory Thoughts

Community Matters and Rural Matters

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So what is rural these days? Does it make a difference in our society today? Does rural matter anymore to us?

Rural definitions are the source of subsidies, reimbursements and the way we separate urban and rural. The challenge for me is that rural should be about more than a definition that has money or lack of it tied to that definition. Rural should be valued as an important part of our society/nation. Rural too often is defined as substandard and often thinks of itself that way. I would like a new definition that is empowering to all.

Rural should be about more than a designation where money is tied to that definition. We have many definitions of rural in America. But does any definition really matter to our citizens? In some respects this may be a matter of attitude over altitude. Many of us know a rural person when we talk and interact with them ,whereas many folks only know rural from the skies as they fly over our pivot circles, grass and crop lands, or wide open spaces.

Some values that most Americans share seem to manifest themselves in particular ways in rural communities.

A. Social interactions in rural areas are more intense because we are interested in long-term relationships. Commonness is appreciated.
B. Generalists are rewarded. We value the versatility of our residents. We like “jack of all trades” people.
C. Our role is known because everyone knows everyone else in rural communities. We carry our jobs as we move through our communities -- every day.
D. Organizational structures depend on informal connections. Who said it is more important that what was said.
E. There is a great amount of homogeneity in rural places. Consensus is necessary, and that often takes time.
F. Values are really important. Think self-sufficiency, behavior over trappings and the

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